

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0024992</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>FAIRVIEW NURSING CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>602 EAST JACKSON STREET</u> <u>DUQUOIN</u> <u>62832</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>PERRY</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>ROGER W. BAGLEY</u> (Title) <u>CONTROLLER</u>	
Telephone Number: <u>(618)542-3441</u> Fax # <u>(618)542-6351</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
IDPA ID Number: <u>370923910001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: _____			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>ROGER W. BAGLEY</u> Telephone Number: <u>(618)549-8331</u> <u>JAMESTOWN MANAGEMENT CORP</u>			

Facility Name & ID Number FAIRVIEW NURSING CENTER# 0024992 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>76</u>	Intermediate (ICF)	<u>76</u>	<u>27,740</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>76</u>	TOTALS	<u>76</u>	<u>27,740</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>16,703</u>	<u>6,975</u>		<u>23,678</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,703</u>	<u>6,975</u>		<u>23,678</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.36%

D. How many bed-hold days during this year were paid by Public Aid?

26 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/10/70

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary NOT APPLICABLE

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	86,996	5,155	5,301	97,452		97,452		97,452		1
2	Food Purchase		73,090		73,090	2,328	75,418	(210)	75,208		2
3	Housekeeping	58,191	7,891		66,082	(117)	65,965		65,965		3
4	Laundry	42,403	6,076		48,479		48,479		48,479		4
5	Heat and Other Utilities			44,131	44,131	336	44,467		44,467		5
6	Maintenance	20,760	10,751	20,745	52,256		52,256		52,256		6
7	Other (specify):*										7
8	TOTAL General Services	208,350	102,963	70,177	381,490	2,547	384,037	(210)	383,827		8
	B. Health Care and Programs										
9	Medical Director			225	225		225		225		9
10	Nursing and Medical Records	595,225	18,099	10,735	624,059	(2,577)	621,482		621,482		10
10a	Therapy	26,764		8,501	35,265		35,265		35,265		10a
11	Activities	30,088	2,467	2,160	34,715	(1,306)	33,409		33,409		11
12	Social Services	19,978		2,160	22,138		22,138		22,138		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	672,055	20,566	23,781	716,402	(3,883)	712,519		712,519		16
	C. General Administration										
17	Administrative	48,553		6,558	55,111	45,785	100,896		100,896		17
18	Directors Fees										18
19	Professional Services			128,583	128,583	(84,168)	44,415	(39,099)	5,316		19
20	Dues, Fees, Subscriptions & Promotions			8,219	8,219	144	8,363	(3,078)	5,285		20
21	Clerical & General Office Expenses	21,718	5,613	7,304	34,635	21,182	55,817	250	56,067		21
22	Employee Benefits & Payroll Taxes			165,763	165,763	10,567	176,330		176,330		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,741	5,741	120	5,861		5,861		24
25	Other Admin. Staff Transportation					1,220	1,220		1,220		25
26	Insurance-Prop.Liab.Malpractice			18,618	18,618	892	19,510		19,510		26
27	Other (specify):*										27
28	TOTAL General Administration	70,271	5,613	340,786	416,670	(4,258)	412,412	(41,927)	370,485		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	950,676	129,142	434,744	1,514,562	(5,594)	1,508,968	(42,137)	1,466,831		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

FAIRVIEW NURSING CENTER

#0024992

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			30,538	30,538	1,270	31,808	31,062	62,870			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							24,292	24,292			32
33	Real Estate Taxes			17,218	17,218	707	17,925		17,925			33
34	Rent-Facility & Grounds			44,828	44,828	3,617	48,445	(44,828)	3,617			34
35	Rent-Equipment & Vehicles			965	965		965		965			35
36	Other (specify):*											36
37	TOTAL Ownership			93,549	93,549	5,594	99,143	10,526	109,669			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,736		6,736		6,736		6,736			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		6,736	41,610	48,346		48,346		48,346			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	950,676	135,878	569,903	1,656,457		1,656,457	(31,611)	1,624,846			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,461	30		9
10	Interest and Other Investment Income	(489)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(210)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	250	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,318)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(460)	20		28
29	Other-Attach Schedule SEE PG 5A	(300)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 14,934		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(46,545)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (46,545)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (31,611)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology					42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
FAIRVIEW NURSING CENTER

Page 5A

ID# 0024992
Report Period Beginning: 01/01/2001
Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DETAIL FOR LINE 29 SCHEDULE VI	\$	1
2	ELIMINATE 1 YR OF 2 YR IDPH LICENSE	(200)	20
3	ELIMINATE CHAMBER OF COMMERCE DUES	(100)	20
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(300)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(210)	0	0	0	0	0	0	0	0	0	0	(210)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(210)	0	0	0	0	0	0	0	0	0	0	(210)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(39,099)	0	0	0	0	0	0	0	0	0	(39,099)	19
20	Fees, Subscriptions & Promotions	(3,078)	0	0	0	0	0	0	0	0	0	0	(3,078)	20
21	Clerical & General Office Expenses	250	0	0	0	0	0	0	0	0	0	0	250	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,828)	(39,099)	0	0	0	0	0	0	0	0	0	(41,927)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,038)	(39,099)	0	0	0	0	0	0	0	0	0	(42,137)	29

Facility Name & ID Number **FAIRVIEW NURSING CENTER**# **0024992**Report Period Beginning: **01/01/2001** Ending: **12/31/2001**

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		FAIR ACRES NURSING HOME	DUQUOIN	Jamestown Mgmt	Carbondale	Management
		SENIOR MANOR NURSING HOME	SPARTA	Fairview Residential	DuQuoin	Owns Building
		CANTERBURY MANOR NURSING CENTER	WATERLOO	Center Land Trust		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 MANAGEMENT FEES	\$ 123,513	JAMESTOWN MANAGEMENT CORPORATION	100.00%	\$ 84,414	\$ (39,099)	1
2	V	30 DEPRECIATION		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%	12,601	12,601	2
3	V	34 RENT	44,828	FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%		(44,828)	3
4	V	32 INTEREST EXPENSE		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%	24,781	24,781	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 168,341			\$ 121,796	\$ * (46,545)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	***OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO COST REPORT***					Hours	Percent	Description	Amount		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **FAIRVIEW NURSING CENTER**# **0024992** Report Period Beginning: **01/01/2001** Ending: **2/31/2001**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Jamestown Management CorporationStreet Address 1001 E. Main Bldg 4ACity / State / Zip Code Carbondale, IL 62901Phone Number (618)549-8331Fax Number (618)549-0133

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	18,158	\$ 8,066	\$	2,488	\$ 1,105	1
2	5	UTILITIES	HOURS OF SERVICE	18,158	2,451		2,488	336	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	10,440	334,264	334,264	1,430	45,785	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	18,158	1,795		2,488	246	4
5	20	LICENSE AND DUES	HOURS OF SERVICE	18,158	1,053		2,488	144	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	7,718	128,698	128,698	1,057	17,626	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	18,158	19,240		2,488	2,636	7
8	22	EMPLOYEE BENEFITS	HOURS OF SERVICE	18,158	63,567		2,488	8,710	8
9	24	SEMINARS	HOURS OF SERVICE	10,440	877		1,430	120	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	10,440	8,910		1,430	1,220	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158	6,513		2,488	892	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158	9,267		2,488	1,270	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	18,158	5,160		2,488	707	13
14	34	RENT	HOURS OF SERVICE	18,158	26,400		2,488	3,617	14
15									15
16									16
17									17
18		*** EXCESS SALARY OF RELATED INDIVIDUAL HAS BEEN							18
19		ELIMINATED PRIOR TO COST REPORT							19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 616,261	\$ 462,962		\$ 84,414	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	BANTERRA BANK		X	FINANCE CONSTRUCTION	\$2,666.00	03-01-99	\$ 310,000	\$ 289,998	03-01-04	0.0825	\$ 24,781	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	BANTERRA BANK		X	OPERATING FUNDS		12-28-01	80,625	80,625	12-28-02	0.0600		6	
7												7	
8												8	
9	TOTAL Facility Related				\$2,666.00		\$ 390,625	\$ 370,623			\$ 24,781	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 390,625	\$ 370,623			\$ 24,781	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIRVIEW NURSING CENTER COUNTY PERRY

FACILITY IDPH LICENSE NUMBER 0024992

CONTACT PERSON REGARDING THIS REPORT ROGER W. BAGLEY

TELEPHONE (618)549-8331 FAX #: (618)549-0133

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 1-61-0270-100	sec 17 twp 06 mg01 s sw sw ne e 215'	\$ 14,317.78	\$ 14,317.78
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 14,317.78	\$ 14,317.78

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

14,640

B. General Construction Type:

Exterior

BRICK

Frame

wood & concrete

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NOT APPLICABLE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	BUILDING	76,230	1968	\$ 3,996	1
2					2
3	TOTALS	76,230		\$ 3,996	3

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/2001

Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1968	1968	\$ 94,863	\$	40	\$ 2,372	\$ 2,372	\$ 79,975	4
5			1968	1968	61,381		20			61,381	5
6			1970	1970	3,953		20			3,953	6
7	18		1970	1970	26,047		38	685	685	21,749	7
8	16		1976	1976	177,922		30	5,931	5,931	152,724	8
	Improvement Type**										
9		FIRE ALARM		1981	1,190		10			1,190	9
10		SEWER LINE		1982	1,056		10			1,056	10
11		PLUMBING IMPROVEMENTS		1984	1,193		10			1,193	11
12		ROOF & LANDSCAPING		1984	1,488		10			1,488	12
13		ACTIVITY ROOM		1986	15,306		20	765	765	12,049	13
14		ACTIVITY ROOM		1987	5,223		20	261	261	3,980	14
15		ROOF & LANDSCAPING		1987	9,775		10			9,775	15
16		PARKING LOT		1987	18,960		15	1,264	1,264	18,644	16
17		SECURITY SYSTEM		1988	2,583		15	172	172	2,322	17
18		RENOVATIONS		1989	2,723		15	182	182	2,366	18
19		HOT WATER HEATER		1990	4,128		15	275	275	3,163	19
20		6 WALL A/C UNITS		1990	7,205		8			7,205	20
21		LANDSCAPING		1990	495		10			495	21
22		SHOWERS / CUBICLE TRACKS		1990	8,459	119	15	564	445	6,486	22
23		ROOF		1990	13,831	439	25	553	114	6,360	23
24		TELEPHONE		1991	3,274		20	164	164	1,722	24
25		WATER HEATER		1991	1,945		15	130	130	1,365	25
26		EMERGENCY LIGHTS		1992	960		15	64	64	608	26
27		SEAL & STIPE PARKING LOT		1994	1,421		5			1,421	27
28		EMERGENCY LIGHTS		1995	994		15	99	99	644	28
29		HOT WATER HEATER		1995	7,433		15	496	496	3,224	29
30		SUBPANELS & CIRCUITS INSTALLED TO A/C		1996	2,394	239	10	240	1	1,320	30
31		PT A/C UNIT		1996	1,163	116	10	116		638	31
32		A/C UNIT		1996	1,071	107	10	107		589	32
33		INSTALLED SERVICE CABLE		1997	7,666	511	15	511		2,300	33
34		A/C UNITS		1998	698	87	10	70	(17)	245	34
35		HOT WATER HEATER		1998	2,985	373	15	199	(174)	697	35
36		OVERBED LIGHTING		1998	8,932	1,116	15	595		2,083	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	CARPET	1998	\$ 588	\$ 73	5	\$ 118	\$ 45	\$ 413		37
38	BASEBOARD HEATING	1998	3,599	450	15	240	(210)	840		38
39	CABINETS & COUNTERTOPS	1998	708	88	5	142	54	497		39
40	WALLPAPER & INSTALLATION	1998	9,457	1,181	5	1,891	710	6,619		40
41	PAINTING	1998	11,779	1,471	5	2,356	885	8,246		41
42	trims, pictures, mirrors, permanent decorative fixtures	1998	2,007	251	5	401	150	1,404		42
43	FLOOR COVE BASE	1998	901	113	5	180	67	630		43
44	MORTON STORAGE BUILDING	1998	3,917	124	15	261	137	653		44
45	BUILDING ADDITION	1998	239,137		15	15,942	15,942	39,855		45
46	PARKING LOT	1998	13,916		15	928	928	3,248		46
47	FLOORING - ADJUSTMENT TO 1998 BLDG ADDITION	1999	737		5	147	147	368		47
48	DOOR ALRM SYSTEM	1999	6,691		10	669	669	1,673		48
49	WALLPAPER & PAINTING	1999	8,314	1,663	5	1,663		4,157		49
50	INSTALL BOOKCASE IN ADMIN OFFICE	1999	333	67	10	66	(1)	165		50
51	LANDSCAPING	1999	5,931	593	10	593		1,483		51
52	SEAL COATED & STRIPED PARKING LOT	1999	1,646	206	8	206		515		52
53	INSTALL TELEPHONES IN BREAKROOM & DINING	1999	777	155	5	155		388		53
54	MOVE PHONE LINES	1999	328	66	5	67	1	167		54
55	ENTRANCE SIGN	1999	1,000	200	5	200		500		55
56	PAINT WINDOW GRIDS	1999	175	35	5	35		88		56
57	INSTALLATION OF FLOORING	1999	8,949	895	10	895		2,237		57
58	FOUNTAIN AND LIGHT	1999	1,774	355	5	355		887		58
59	balance of trims, pictures, mirrors, permanent decorative	1999	3,952	136	5	790	654	1,975		59
60	fixtures to refurbish the building									60
61	AWNINGS	1999	420	73	5	84	11	210		61
62	Labor & materials to remove existing wall & rebuild new	1999	8,559	856	10	856		2,140		62
63	wall, relocate plumbing & electrical services, install									63
64	cabinetry & countertops, and installed new tile flooring									64
65	Labor & materials to gut an existing bathroom and rehab									65
66	room to create 2 new bathrooms, and storage areas for									66
67	housekeeping and dietary(to be completed in 2000).									67
68	labor & materials to install new cabinets, relocate plumbing									68
69	& electric, repair drywall & paint the breakroom									69
70	TOTAL (lines 4 thru 69)		\$ 834,312	\$ 12,158		\$ 45,055	\$ 33,418	\$ 493,768		70

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number FAIRVIEW NURSING CENTER

0024992

Report Period Beginning:

01/01/2001

Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 834,312	\$ 12,158		\$ 45,055	\$ 32,897	\$ 493,768	1
2	Labor & materials to complete 1999 bathroom project.	2000	20,296	2,030	10	2,030		3,045	2
3	Installed ceramic tile, sinks, toilet stool, showers, and								3
4	lighting fixtures.								4
5	Labor & material to remove existing wall in order to convert	2000	11,212	1,121	10	1,121		1,682	5
6	storage room into a resident room. Removed existing								6
7	closets, installed shower area, relocated doors, electrical,								7
8	and plumbing services, repaired and painted drywall, &								8
9	relocated call lights								9
10	Excavate & replace driveway asphalt & fill in crack with tar	2001	3,075	102	15	103	1	103	10
11	Reinforce & raise sinking floor on B wing	2001	7,380	246	15	246		246	11
12	Gut beauty shop area and construct a new handicapped	2001	16,165	538	15	539	1	539	12
13	bathroom. New wiring, plumbing, flooring, shower, toilet,								13
14	sink, door, sprinkler heads, cubicle tracks & curtains,								14
15	and cove base								15
16	Sewer repair to 3 bed ward bathroom. Removed concrete	2001	2,800	93	15	93		93	16
17	replaced deteriorated sewer line install new line and new								17
18	clean out and pour new floor.								18
19	Relocate beauty shop to PT area. Installed lines, clean out	2001	1,223	41	15	41		41	19
20	& shut off valves, drill & knock out outside brick wall								20
21	install fan, finish drywall, paint, install tile on drywall,								21
22	install sink & shelves								22
23	Convert existing bathroom to handicapped bathroom.	2001	7,124	237	15	237		237	23
24	remove tile, install box for call lights, tear out & reconstruct								24
25	showers, tile walls & showers, install handrails in tub &								25
26	showers, hang tracks & curtains, put new lever handle door								26
27	lever.								27
28	Add fan to isolation room for medicare compliance	2001	386	13	15	13		13	28
29	Install 2 sprinkler heads in store room & water heater closet	2001	338	11	15	11		11	29
30	Upgrade emergency lighting & moved annunciator panel	2001	15,138	757	10	757		757	30
31	& smoke detectors								31
32	Upgrade nurses call system	2001	645	32	10	32		32	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 920,094	\$ 17,379		\$ 50,278	\$ 32,899	\$ 500,567	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 107,227	\$ 7,480	\$ 10,489	\$ 3,009	variable	\$ 60,050	71
72	Current Year Purchases	5,679	5,679	833	(4,846)	variable	833	72
73	Fully Depreciated Assets	146,845				variable	146,845	73
74								74
75	TOTALS	\$ 259,751	\$ 13,159	\$ 11,322	\$ (1,837)		\$ 207,728	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	JAMESTOWN ALLOCATION			\$	\$ 1,270	\$ 1,270	\$		\$ 9,774	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 1,270	\$ 1,270	\$		\$ 9,774	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,183,841	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,808	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 62,870	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,062	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 718,069	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	PARKING LOT 1968	\$ 3,720	\$	\$ 3,720	86
87	ROOF 1968	7,440		7,440	87
88	FIRE ALARM 1969	130		130	88
89	EQUIPMENT VAR	24,719		24,719	89
90	Assets no longer in us (obsolete)				90
91	TOTALS	\$ 36,009	\$	\$ 36,009	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **NOT APPLICABLE**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **965** Description: **dish machine (759), freezer (10), tiller (25), storage (171)**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **/2002** \$

13. **/2003** \$

14. **/2004** \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. <u>we only hire trained aides</u>	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify): oxygen	39/2					6,736		6,736	13
14	TOTAL			\$		\$	\$ 6,736		\$ 6,736	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 55,678	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	273,907		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,625		6
7	Other Prepaid Expenses	8,509		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INVESTMENT	6,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 345,719	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	126,985		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	374,216		16
17	Accumulated Depreciation (book methods)	(342,137)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 159,064	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 504,783	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 34,971	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,934		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,859		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	BANTERRA BANK LINE OF CREDIT	80,625		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 170,889	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 170,889	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 333,894	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 504,783	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 365,837	1
2	Restatements (describe):		2
3	2000 ILLINOIS REPLACEMENT TAX	(1,518)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 364,319	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	108,690	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(126,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) EXCESS SALARIES ELIMINATED	(13,115)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (30,425)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 333,894	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,763,008	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,763,008	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,650	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,650	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	489	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 489	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,765,147	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	381,490	31
32	Health Care	716,402	32
33	General Administration	416,670	33
B. Capital Expense			
34	Ownership	93,549	34
C. Ancillary Expense			
35	Special Cost Centers	6,736	35
36	Provider Participation Fee	41,610	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,656,457	40
41	Income before Income Taxes (line 30 minus line 40)**	108,690	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 108,690	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
 If Repl. Tax deducted on federal return

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **FAIRVIEW NURSING CENTER**# **0024992**Report Period Beginning: **01/01/2001**

Ending:

12/31/2001**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,016	2,080	\$ 38,223	\$ 18.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,084	2,355	36,959	15.69	3
4	Licensed Practical Nurses	12,148	13,256	165,262	12.47	4
5	Nurse Aides & Orderlies	36,691	38,933	352,365	9.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,854	2,095	26,764	12.78	8
9	Activity Director	2,749	3,004	30,088	10.02	9
10	Activity Assistants					10
11	Social Service Workers	1,786	1,955	19,978	10.22	11
12	Dietician					12
13	Food Service Supervisor	2,004	2,135	18,432	8.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,465	8,989	68,564	7.63	15
16	Dishwashers					16
17	Maintenance Workers	1,835	1,955	20,760	10.62	17
18	Housekeepers	6,420	7,001	58,191	8.31	18
19	Laundry	3,936	4,223	42,403	10.04	19
20	Administrator	1,944	2,080	48,553	23.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,994	2,082	21,718	10.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>WARD CLERK</u>	271	327	2,416	7.39	33
34	TOTAL (lines 1 - 33)	86,197	92,470	\$ 950,676 *	\$ 10.28	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	100	\$ 5,301	1/3	35
36	Medical Director		225	9/3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		420	10/3	39
40	Physical Therapy Consultant	140	8,323	10A/3	40
41	Occupational Therapy Consultant	1	81	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	97	10A/3	43
44	Activity Consultant	42	2,160	11/3	44
45	Social Service Consultant	42	2,160	12/3	45
46	Other(specify)				46
47	<u>UTILIZATION REVIEW</u>		225	10/3	47
48	<u>PURCHASING</u>		1,058	19/3	48
49	TOTAL (lines 35 - 48)	326	\$ 20,050		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	47	1,267	10/3	51
52	Nurse Aides	485	8,823	10/3	52
53	TOTAL (lines 50 - 52)	532	\$ 10,090		53

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING	1996	\$ 1,784	3	\$ 595	\$ 297	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
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18													
19													
20	TOTALS		\$ 1,784		\$ 595	\$ 297	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number FAIRVIEW NURSING CENTER

STATE OF ILLINOIS

0024992

Report Period Beginning: 01/01/2001

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Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 4 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 41,610
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,857 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

FAIRVIEW NURSING CENTER INC.
RECLASSIFICATIONS ON DPA COST REPORT
12/31/2001
PAGES 3 & 4 COLUMN 5
ID # 0024992

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
	2 FOOD PURCHASES	2879	
10	NURSING & MEDICAL RECORDS RECLASSIFY FOOD SUPPLEMENTS		2879
	21 CLERICAL & GENERAL OFFICE EXP	920	
10	NURSING & MEDICAL RECORDS RECLASSIFY OFFICE SUPPLIES		920
	2 FOOD PURCHASE	1306	
11	ACTIVITIES RECLASSIFY FOOD PURCHASED FOR ACTIVITY DEPT		1306
10	NURSING & MEDICAL RECORDS	1222	
3	HOUSEKEEPING RECLASSIFY SOAP & SHAMPOO		1222
	22 EMPLOYEE BENEFITS	1857	
2	FOOD PURCHASES RECLASSIFY EMPLOYEE MEALS		1857
VARIOUS	VARIOUS LINE ITEMS	84414	
19	PROFESSIONAL SERVICES SEE SCHEDULE VIII FOR BREAKDOWN		84414